DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To:	All Providers Managed Care Organizations	**Memorandum No: 07-70** **Issued:** December 3, 2007
From:	Douglas Porter, Assistant Secretary Health and Recovery Services Administration (HRSA)	**For information contact:** 800.562.3022 (option 2) or go to: http://maa.dshs.wa.gov/contact/prucontact.asp
Subject:	**State of Washington Medicaid and SCHIP programs selected for Payment Error Rate Measurement (PERM) in FY 2008**	

The purpose of this memorandum is to clarify the providers' role in the Payment Error Rate Measurement (PERM) program.

What is PERM?

The Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program in response to the Improper Payment Information Act of 2002. This act requires federal agencies to review annually programs they oversee that are susceptible to significant erroneous payments and to report the improper payment estimates to Congress. OMB identified the Medicaid and State Children's Health Insurance Program (SCHIP) as programs at risk for significant erroneous payments.

The PERM program is a comprehensive, ongoing federal audit to measure how frequently errors occur when providers submit claims to states and when states pay those claims. This federal audit includes:

- Examining submitted claims that have been approved and paid;
- Examining submitted claims that have been denied; and
- A sampling and review of eligibility determinations.

All 50 states will be measured in three-year cycles. Washington, along with 16 other states, has been selected to undergo the federal audit for federal fiscal year 2008. A state and national payment error rate will be announced after all data have been collected and reviewed.

Who manages the PERM program?

The PERM program is managed by CMS. Contractors hired by CMS will measure the accuracy of Medicaid and SCHIP payments made by states for services rendered to eligible recipients.

How will improper payments be measured?

Under the PERM program, CMS uses three national contractors to measure improper payments in Medicaid and SCHIP.

Your interactions in this process will be primarily with the documentation/database contractor (DDC), Livanta LLC. This contractor will collect copies of medical policies from the state and medical records from you either in hardcopy or electronic format.

Medical records are needed by the claim review contractor to determine whether fee-for-service Medicaid and SCHIP claims were correctly paid.

What will happen if a claim I submitted is selected for review by the PERM contractor?

If a claim for a service you rendered to either a Medicaid or SCHIP recipient is selected for review, the DDC will contact you for a copy of the related medical records to support the medical review of the claim.

> **Note:** It is the billing provider's responsibility to ensure that any and all supporting medical records are submitted in a timely manner. This includes timely submission of medical records from other provider(s) who rendered service(s) for the payment under review.

The DDC will verify your name and address and how you want to receive the request for medical records (i.e., facsimile or U.S. mail).

What rules and regulations authorize the collection of protected health information by CMS?

Understandably, you may be concerned with maintaining the privacy of patient information. Permission to collect and review medical records is addressed in the following documents:

- **Health Insurance Portability and Accountability Act**

  The collection and review of protected health information contained in individual-level medical records for payment review purposes is permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164.

- **Social Security Act**

  Providers are required by Section 1902(a)(27) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS with information (including medical records) regarding any payments claimed by the provider for rendering services.

  Section 2107(b)(1) of the Act requires a State plan for SCHIP to provide assurances to the Secretary that the State will collect and provide to the Secretary any information required to enable the Secretary to monitor program administration and compliance and to evaluate and compare the effectiveness of States' SCHIP plans.

- **Core Provider Agreement**

  Section 5 states, in part, that for six (6) years from the date of service the provider shall keep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services and claims submitted to the department.

  The provider shall make available upon request appropriate documentation, including client records, supporting material, and any information regarding payments claimed by the provider, for review by the professional staff within the Department of Social and Health Services or the Secretary of the U.S. Department of Health and Human Services.

How long will I have to submit the claim documentation?

You must submit the documentation electronically or in hard copy within 60 calendar days of receipt of the request. If additional information is requested after your original submission, you will have 15 calendar days to respond. Health and Recovery Services Administration (HRSA) staff may contact you to assist in identifying the records required by the DDC.

Will there be any reminders before the deadline expires?

The DDC will contact any provider who has not submitted documentation within 15 calendar days after the original request was made. A second contact will be made if a provider has not submitted documentation within 35 days after the original request for records was made.

If the DDC contacts you for documentation in addition to your original submission, you will have 15 calendar days to respond.

What happens if I miss the deadline?

CMS records no response or insufficient documentation as an error. It is important that you submit all requested documentation within the stated timeframe. Past PERM reviews in other states have shown that the largest cause of errors in medical reviews is no documentation or insufficient documentation. If a provider does not respond by calendar day 60, the DDC will send a written notification of the error to the provider and the Washington State PERM Project Manager. Failure to comply with requests for records may result in an expanded audit of your claims and issuance of an overpayment notice.

Who do I contact if I have questions?

Address questions about this matter to Sandra Cashman, Washington State PERM Project Manager at 360.725.1291 or cashmsm@dshs.wa.gov.

How do I conduct business electronically with HRSA?

You may conduct business electronically with HRSA by accessing the WAMedWeb at http://wamedweb.acs-inc.com.

How can I get HRSA's provider documents?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.